Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name _____

Date of Birth / / **Sex:** ☐ **female** ☐ **male**

Vaccine				Date
Hepatitis B			1	
			2	
			3	
DTaP	**DT**	**Td**	1	
			2	
			3	
			4	
			5	
			6	
			7	
IPV			1	
			2	
			3	
			4	
PCV7 (Pneumococcal conjugate 7-valent)			1	
			2	
			3	
			4	

Vaccine		Date
Hib	1	
	2	
	3	
	4	
MMR	1	
	2	
Varicella	1	
	2	
Hepatitis A	1	
	2	
PPV23 (Pneumococcal polysaccaride 23-valent)	1	
	2	
Influenza	1	
	2	
	3	
Other:		

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also 4 Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* **Date:** / /

Signature: _____

Facility name: _____